

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **DOWNGRADE OF AN ALS UNIT FROM** (PARAMEDIC, MICN)  
**TEMPORARILY UPGRADED ASSESSMENT UNIT** REFERENCE NO. 416.2

Use this form within 30 days of using the Temporary Upgrade of an Assessment Unit to an ALS Unit form.

Department:	*
Unit Number:	*
Unit Address:	*
Date of Upgrade:	*
Time of Upgrade:	*

**Authorized By:**

Name:	*
Title:	*
Phone Number:	
Email:	

**CHECK:**

- ☐ \* A unit inventory inspection in accordance with the most current Reference No. 704, Assessment Unit Inventory, was performed.
- ☐ \* All supplies/equipment authorized for ALS Units under Reference No. 703 have been removed.
- ☐ \* All controlled substances and controlled substance logs have been removed from unit.

I attest that the above statements are correct and this unit only contains the equipment/supplies listed in Reference No. 704 and is in good working order:

\_\_\_\_\_  
\*Signature Title (Captain or Chief level) Date

Prehospital Care Manual:

Ref. No. 702, **Controlled Drugs Carried on ALS Units**

Ref. No. 703, **ALS Unit Inventory**

Ref. No. 704, **Assessment Unit Inventory**

*Originally signed forms (or digitally signed forms) are to be maintained within station files.*